

US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Oct/23/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Caudal epidural steroid injection with anesthesia under fluoroscopy, outpatient

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for caudal epidural steroid injection with anesthesia under fluoroscopy, outpatient is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. On this date the patient was involved xxxxx. Office visit note dated xxxx indicates that patient expressed interest in proceeding with lumbar injections as treatment. Predominate pain is located in the lower back and does not radiate. Previous treatments are listed as medications, injections and surgery. The patient underwent cervical fusion, knee surgery and umbilical hernia surgery in xxxx. The patient underwent bilateral L5-S1 lumbar epidural steroid injection on xxx and xxxx and multiple caudal epidural steroid injections in xxx, xxx and xxxx. On physical examination there are no focal neurologic deficits. Gait is within normal limits. RIs is negative.

Initial request for caudal epidural steroid injection with anesthesia under fluoroscopy outpatient was non-certified on xxxx noting that the neurologic exam is normal and negative and this was confirmed with the provider. The lack of clinical findings does not support doing an epidural steroid injection per ODG criteria. The anesthesia is not indicated either as the injection is not indicated. Peer to peer note dated xxxx indicates that the patient has undergone 7 previous caudal epidural steroid injections with improvement. The denial was upheld on appeal dated xxxx noting that the records provided for review do not address this prior reviewer's concerns. The most recent evaluation noted the patient's low back pain only and there were no indications of any significant radicular symptoms in the lower extremities. The patient's physical exam findings found no focal neurological deficits that would meet guideline recommendations for lumbar epidural steroid injections. The records also did not identify any procedure anxiety issues to support sedation. The clinical documentation provided for review does not meet guideline recommendations for the submitted request or address the prior reviewer's concerns

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on XX/XX/XXXX. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. For epidural steroid injections, the Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy and there are no imaging studies/electrodiagnostic results submitted for review. The patient has reportedly undergone 7 prior caudal epidural steroid injections; however, the patient's objective functional response to these injections is not documented to establish efficacy of treatment as required by the Official Disability Guidelines. There is no documentation of extreme anxiety or needle phobia to support anesthesia. As such, it is the opinion of the reviewer that the request for caudal epidural steroid injection with anesthesia under fluoroscopy, outpatient is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)